STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
FIRST FLOOR, CORDELL HULL BUILDING
425 FIFTH AVENUE NORTH
NASHVILLE, TN 37247-1010

Local (Nashville Calling Area) 615-532-3202
Nationwide (toll free) 1-888-310-4650

INSTRUCTIONS

PRECEPTOR APPLICATION

TENNESSEE BOARD OF

NURSING HOME ADMINISTRATORS

1. Complete and have notarized the Application for Preceptor.

2. Complete and have notarized the Application for Administrator in Training Facility.

SEND THE TWO APPLICATIONS LISTED ABOVE WITH THE FOLLOWING TO THE BOARD'S ADMINISTRATIVE OFFICE.

3. Copy of the certificate awarded at the completion of the twelve (12) hour Board approved Preceptor Training and Orientation Course required to become a Preceptor.

4. Copy of most recent survey and plan of correction at facility described in the Application for Administrator in Training Facility.

ALL INFORMATION LISTED ABOVE MUST BE RECEIVED IN THE BOARD'S ADMINISTRATIVE OFFICE NO LATER THAN THE 15TH OF THE MONTH PRECEDING THE MEETING DATE. ANY APPLICATIONS NOT RECEIVED DURING THIS TIME FRAME WILL BE HELD OVER TO THE NEXT BOARD MEETING FOR REVIEW.

SEND ALL INFORMATION TO:

Board of Nursing Home Administrators
First Floor, Cordell Hull Building
425 Fifth Avenue, North
Nashville, TN 37247-1010

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
FIRST FLOOR, CORDELL HULL BUILDING
425 FIFTH AVENUE NORTH
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Nationwide (toll free) 1-888-310-4650

Tennessee State Board of
Nursing Home Administrators

APPLICATION FOR PRECEPTOR

Full Name: _____
Last First Middle

Business Address: _____
Street and Number

_____
City, State, Zip

Telephone (Area Code and Number): _____

Sex: _____ Date of Birth: _____

Social Security Number: _____

Nursing Home Administrator's License Number: _____

Date of original license issued in Tennessee: _____

Has the license been active since that time? Yes ( ) No ( )

If no give details: _____

_____

_____

Administrator is defined as the individual directly responsible for planning, organizing, directing and controlling the operation of a licensed nursing home in Tennessee.

PH #3586 RDA #1786

CRITERIA FOR A PRECEPTOR

1. A preceptor shall be currently licensed as a Nursing Home Administrator in Tennessee. He or she shall have had a valid license during the entire three (3) year qualifying period with at least the last year being in Tennessee.

   Give license history for qualifying period: _____

   _____

   _____

2. Administrators serving as preceptors shall have a minimum of three (3) years full time institutional administrative experience in a licensed nursing home during the last five (5) years. Administrator is defined as the individual directly responsible for planning, organizing, directing and controlling the operation of a licensed nursing home in Tennessee.

   Give administrative history for qualifying period: _____

   _____

   _____

3. An assistant administrator serving as a preceptor shall have a minimum of six (6) years full time experience in licensed nursing homes during the last ten (10) years. Assistant administrator is defined as the person directly responsible to the administrator with the same responsibilities defined above in the administrator's absence.

   Give administrative history for qualifying period: _____

   _____

   _____

4. Preceptors must have at least seventy-two (72) semester hours college credit. They may substitute one (1) year full time institutional administrative experience, beyond the minimum three (3) years, for twenty-four (24) semester hours college credit.

   Give educational history for qualifying: _____

   _____

   _____

5. Preceptors shall have successfully completed twelve (12) hours of Board approved Preceptor Training and Orientation.

   Give date and location of Board Approved Course successfully completed:

   _____

   _____

   _____

6. Preceptors shall have no disciplinary convictions within the past ten (10) years.

   I have ( ) have not ( ) had disciplinary convictions during the past ten (10) years. If have had disciplinary convictions, please explain:

I, _____, the undersigned, who desire to qualify as a Preceptor in the Sate of Tennessee, hereby make an application to the Tennessee State Board of Examiners for Nursing Home Administrators. All facts, statements and answers contained in this application are true and correct. I have not omitted any information which might be of value to the Board in determining any qualifications and character, whether it is called for or not and I understand that nay falsification, omission or withholding of information or facts concerning my qualifications as an applicant shall be sufficient to bar me from this or any future certification given by the Tennessee State Board of Examiners for Nursing Home Administrators for Preceptors.

_____
Signature of Applicant

_____
Date

Date _____

County of _____

State of _____

Sworn to and subscribed before me by the above this ____ day of _____, _____.

_____
Notary Public

My Commission Expires: _____

PH #3586 RDA #1786

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
FIRST FLOOR, CORDELL HULL BUILDING
425 FIFTH AVENUE NORTH
NASHVILLE, TN 37247-1010

Local (Nashville Calling Area) 615-532-3202
Nationwide (toll free) 1-888-310-4650

Tennessee Board of Examiners for
Nursing Home Administrators

APPLICATION
ADMINISTRATOR IN TRAINING FACILITY

The primary training of an Administrator-In-Training will take place in the Nursing Home of which the Preceptor is Administrator.

Name of Nursing Home: _____

Address: _____

_____
Street and Number

_____
City, State, Zip

Telephone (Area Code and Number): _____

A. Date of latest licensure survey: _____

Attach a copy of the latest licensure survey and the plan of correction for any deficiencies.

B. The facility must have an organizational structure with clearly defined and staffed departments, each with a designated department head. Except for administration, the designated department head may not be the administrator.

DEPARTMENT	NAME OF DEPARTMENT HEAD
Administration:	_____
Nursing:	_____
Dietary:	_____
Social Services and Activities:	_____
Medical Records:	_____
Housekeeping, Maintenance, Laundry:	_____
Number of Beds:	_____

I, _____, the Administrator of Home, hereby make application to the Tennessee State Board of Examiners for Nursing Home Administrators for approval of this Nursing Home as an Administrator-In-Training facility. All facts, statements and answers contained in this application are true and correct, to the best of my knowledge. I have not omitted any information which might be of value to the Board in determining the qualifications of this Nursing Home, whether it is called for or not, and I understand that any falsification, omission or withholding of information or facts concerning the home's qualifications shall be sufficient to bar it from this or any future certification given by the Tennessee State Board of Examiners for Nursing Home Administrators as an A.I.T. training site.

_____
Signature of Administrator

_____
Date

County of _____

State of _____

Sworn to and subscribed before me by the above this ____ day of _____, _____.

_____
Notary Public

My Commission Expires: _____

PH #3586 RDA #1786

KR/G5098231/NHA-ms.70

TENNESSEE DEPARTMENT OF

HEALTH

MANDATORY

PRACTITIONER

PROFILE QUESTIONNAIRE

PURSUANT TO TENNESSEE CODE ANNOTATED SECTION 63-51-101 et seq, LAWS OF TENNESSEE

FOR

LICENSED HEALTH CARE PROVIDERS

FOREWORD

The Health Care Consumer Right-to-Know Act of 1998, T.C.A. § 63-51-101 et seq, requires designated licensed health professionals to furnish certain information to the Tennessee Department of Health. The information specified in the law is contained in the attached questionnaire. From the information submitted, the Department will compile a practitioner profile which is required to be made available to the public via the World Wide Web and toll-free telephone line after May 1, 1999. Each practitioner who has submitted information must update that information in writing by notifying the Department of Health, Healthcare Provider Information Unit, within 30 days after the occurrence of an event or an attainment of a status that is required to be reported by the law. A copy of your initial or updated profile will be furnished to you for your review prior to publication. That opportunity will allow you to make corrections, additions and helpful explanatory comments. Failure to comply with the requirement to submit and update profiling information constitutes a ground for disciplinary action against your license. A blank copy of the profile may be obtained from the following web site address: http://tennessee.gov/health**.**

On the department's homepage, under Licensing, click on "Health Professional Boards"; then select the appropriate board.

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SECTION I: GENERAL INSTRUCTIONS

- **Read all instructions thoroughly before completing the profile questionnaire. Incomplete or omitted information may delay meeting the mandatory reporting requirement.**
- **Incomplete or illegible profiles will be returned to the provider for resubmission.**
- **Some questions do not apply to every profession. If a question does not apply to you, indicate so by checking the "Does not apply" box.**
- **Provide only information for the previous ten (10) years where indicated on the questionnaire.**
- **Complete the questionnaire and attachments by typing or printing your response in block letters in ballpoint pen. Incomplete or illegible profiles will be returned to the provider for resubmission. Some questions do not apply to every profession. If a question does not apply to you, indicate so by checking the "Does not apply" box.**
- **DO NOT RETURN THESE INSTRUCTIONS WITH THE QUESTIONNAIRE TO THE DEPARTMENT.**
- **You may have completed a similar questionnaire for another state's licensing board. If so, Tennessee law still requires you to complete and submit this form.**
- **If you have an active Tennessee license you are required to complete the questionnaire. This includes those practitioners who are retired or no longer practicing.**

- **Mail the completed ORIGINAL profile questionnaire <u>within thirty (30) days of its receipt by the provider</u> to:**

Healthcare Provider Information Manager
Tennessee Department of Health
Division of Health Related Boards
227 French Landing, Suite 300
Heritage Place Metro Center
Nashville, TN 37243
1-800-778-4123
Local - (615) 532-3202

- **<u>Keep a copy of the questionnaire for your records.</u>**

✓CHECKLIST

Before you mail your questionnaire:

- ☐ Have all questionnaire and supplemental pages been completed with the name of the practitioner, profession and license number at the top of the page?

- ☐ Have supplemental pages been clearly labeled with the corresponding question for which the response is being provided?

- ☐ Have you retained a copy of your signed questionnaire?

SECTION II:

COMPLETING THE PROFILE QUESTIONNAIRE

QUESTIONNAIRE DEADLINE

The provider must submit the questionnaire on or before thirty (30) days from its receipt.

COMPLETING THE FORMS

Complete all forms by printing neatly in block letters in ballpoint pen or typing the information. If a question does not apply to you, indicate so by checking the "Does not apply" box. **Illegible questionnaires will be returned.**

The following numbered parts correspond to the matching number on the questionnaire form.

I. PRACTITIONER DATA

Complete part one (1) noting the following:

- License number: Fill in your license number and indicate your profession in the space provided.
- Social security number: **Your social security number will not be published or in any way given out to the public. It is required for in-house tracking purposes only.**
- Address: Complete mailing and practice address (if applicable). Retirees: Write in "N/A" for practice address.

II. GRADUATE/POSTGRADUATE MEDICAL/PROFESSIONAL EDUCATION AND TRAINING

List chronologically all medical/health professional related graduate/postgraduate education and training completed. Exclude any program or courses taken to satisfy continuing education requirements for licensure renewal. Provide information about health related degrees you have received including your licensure degree.

III. SPECIALTY BOARD CERTIFICATIONS

Provide information on any certification, specialty or subspecialty from any specialty board recognized by the American Medical Association, American Osteopathic Medical Association, American Podiatry Association, American Chiropractic Association, American Dental Association or any other specialty certifying body as determined by your Tennessee licensing board.

IV. FACULTY APPOINTMENTS

Answer ALL yes/no questions with a “yes” or “no” response. A brief statement in the space provided should follow a "yes" answer. If the space is insufficient for your response, attach an additional page, being sure to number the response to match the appropriate question.

V. STAFF PRIVILEGES

List all hospitals at which you hold staff privileges. This includes:

- Licensed hospitals-this term is defined at T.C.A. § 68-11-201.

In the spaces provided, answer information about the TennCare plans in which you participate, if any. If there are more than five (5), please send attachment.

VI. FINAL DISCIPLINARY ACTION

These questions refer to final disciplinary or adverse actions taken within the previous **ten (10) years**, whether in this state or any other jurisdiction. The term **final** means the matter was fully adjudicated at a hearing and the appeal’s period expired, or that the applicable board issued an agreed order or consent decree.

In the “Description of Violation” spaces, indicate the nature of the conduct in question such as malpractice, unethical conduct, drug-related, sex related, impairment, fraud, etc.

In the “Description of Action” spaces, indicate the type of disciplinary action imposed against your professional license.

The term **disciplinary action** includes, but is not limited to:

- Probation
- Limitation/Restriction
- Suspension
- Revocation
- Voluntary relinquishment in lieu of disciplinary action
- Any other adverse action taken against a license or privilege by a medical/health related institution
- Compulsory surrender of license or privilege
- Civil or other monetary fine or penalty
- Resignation from or non-renewal of medical staff membership at a hospital in lieu of, or in settlement of, a pending disciplinary case related to competence or character
- Restriction of privileges in lieu of, or in settlement of, a pending disciplinary case related to competence or character

If you answer “yes” to any of the questions in this section and if the action is under appeal, you must attach a copy of the notice of appeal. Note: You must submit a copy of the final written order of

disposition immediately after the appeal is disposed of by the adjudicating authority. Please read questions VII B and C in their entirety before answering those questions.

VII. CRIMINAL OFFENSES

This part requires you to report any state or federal felony criminal offense convictions. It also requires the reporting of misdemeanor offenses, regardless of classification, in which any element of the offense involves sex; alcohol or drugs; physical injury or threat of injury to any person; abuse or neglect of any minor, spouse or the elderly; fraud or theft in Tennessee or another jurisdiction; or unlicensed practice of a profession within the most recent ten (10) years. If you answer "yes" to this question and the offense is under appeal, you must submit a copy of the notice of appeal of that criminal offense. Immediately upon disposition of the appeal, you must submit a copy of the final written order of disposition. If any misdemeanor conviction reported is expunged, a copy of the order of expungement signed by the judge must be submitted to the Department before the conviction will be removed from any profile.

VIII. LIABILITY CLAIMS

This section requires you to indicate all medical malpractice court judgments, arbitration awards, or settlements in which a payment was awarded to a complaining party beginning with judgments or settlements entered or executed after May 19, 1998. That means if the act or event leading to the claim occurred in, for instance, 1995, but was finally adjudicated against you after May 19,1998, you must indicate that claim in the space provided. JUDGMENTS OR SETTLEMENTS BELOW THE THRESHOLD AMOUNT ESTABLISHED BY YOUR TENNESSEE LICENSING BOARD ARE NOT REQUIRED TO BE SUBMITTED. To find out the threshold amount established by your board, consult your board's web page at www.state.tn.us/health/ or call 1-800-778-4123. Pending malpractice claims are not required to be reported unless/until final adjudication against you.

IX. OPTIONAL INFORMATION

This section is voluntary. You may list, briefly describe, and submit any information/documentation regarding your professional practice in the spaces provided. Attach an additional sheet labeled with the question number if additional space is required.

Practitioner's Name _____ **License #** _____
Profession _____

SECTION III:

HEALTHCARE PROVIDER INFORMATION MANAGER
TENNESSEE DEPARTMENT OF HEALTH
DIVISION OF HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE METRO CENTER
NASHVILLE, TENNESSEE 37243

I. PRACTITIONER DATA

A. PROFESSIONAL LICENSE NUMBER: _____ PROFESSION: _____

B. SOCIAL SECURITY NUMBER: _____ (**This will not be published as part of the profile or website).**

C. NAME (INCLUDE MAIDEN AND ON 2ND/3RD LINES ANY ALIASES, IF APPLICABLE):
CURRENT NAME:

_____
(LAST) (FIRST) (MIDDLE AND MAIDEN NAME) (IF APPLICABLE)

FORMER NAME(S):

_____
(LAST) (FIRST) (MIDDLE)

_____
(LAST) (FIRST) (MIDDLE)

D. MAILING ADDRESS:

_____
(STREET AND NUMBER)

_____
(CITY) (STATE) (ZIP CODE)

PRIMARY PRACTICE ADDRESS: (This will be published as part of the profile and the web site).

_____
(PRACTICE NAME)

_____
(STREET AND NUMBER)

_____
(CITY) (STATE) (ZIP CODE)

E. TELEPHONE:(_____)_____**(This will not be published as part of the profile or the web site).**

F. LANGUAGES, OTHER THAN ENGLISH: Indicate languages other than English or translation services that may be available at your primary practice location.

1. _____
2. _____

G. SUPERVISING PHYSICIAN: If you are required by law to be supervised by a physician (physician assistant or nurse practitioner) indicate the name(s) and address(es) of each supervising physician. If you need more space, attach additional sheets:

1. _____
2. _____

Practitioner's Name _____ **License #** _____
Profession _____

II. GRADUATE/POSTGRADUATE MEDICAL/PROFESSIONAL EDUCATION AND TRAINING

A. What school(s)/educational programs have you attended? And, what type(s) of degree(s) do you hold? Do not include coursework taken to meet the continuing education requirement for licensure renewal. (Authority: T.C.A. §63-51-105(a)(6) and (7))

PROGRAM/INSTITUTION	CITY/STATE/ COUNTRY	DATE OF GRADUATION	TYPE OF DEGREE
1.			
2.			
3.			
4.			
5.			
6.			

B. List in chronological order from date of graduation to the present, all completed medical/professional graduate and/or post-graduate training (internship, residency, fellowship or other program). Do not include coursework taken to meet continuing education requirements for licensure renewal. (Authority: T.C.A. § 63-51-105(a)(6))

PROGRAM AND SPECIALTY AREA (INTERNSHIP, RESIDENCY, FELLOWSHIP, ETC.)	LOCATION OF TRAINING (CITY,STATE, COUNTRY)	FROM MM/DD/YYYY	TO MM/DD/YYYY
1.			
2.			
3.			
4.			

Practitioner's Name _____ **License #** _____
Profession _____

III. SPECIALTY BOARD CERTIFICATIONS

Do you hold a certification, specialty or subspecialty from any specialty board recognized by the board regulating the profession for which you are licensed? (see instructions) (Authority: T.C.A. § 63-51-105(a)(8)) If "Yes", complete section below. YES ❒ NO ❒

CERTIFYING BODY/BOARD INSTITUTION	CERTIFICATION/SPECIALTY/SUBSPECIALTY
1.	
2.	
3.	
4.	
5.	

IV. FACULTY APPOINTMENTS

A. Have you had the responsibility for graduate medical education within the last ten (10) years? (Authority: T.C.A. § 63-51-105(a)(10)) YES ❒ NO ❒

B. Do you currently hold a faculty appointment at a medical/health related institution of higher learning? (Authority: T.C.A. § 63-51-105(a)(10)) YES ❒ NO ❒

If "YES", list the title of the appointment and name(s) and city/state of institution(s). (Attach additional sheets, clearly labeled with this question number, if necessary.)

	TITLE	INSTITUTION	CITY/STATE
1.			
2.			
3.			
4.			

V. STAFF PRIVILEGES

A. Do you currently hold staff privileges at a hospital? (Authority: T.C.A. §63-51-105(a)(a)) YES ❒ NO ❒

If "YES", list each hospital at which you currently have staff privileges: (Attach additional sheets, clearly labeled with this question number, if necessary)

	Name of Hospital	City/State
1.		
2.		
3.		
4.		
5.		

Practitioner's Name _____ **License #** _____
Profession _____

B. Do you currently participate in any TennCare plan? (Authority: T.C.A. § 63-51-105(a)(16)) YES ❒ NO ❒
If "YES", list each plan in which you currently participate:

Name of TennCare Plan
1.
2.
3.
4.
5.

VI. FINAL DISCIPLINARY ACTION (See Instructions)

A. Within the previous ten (10) years, have you ever had any final disciplinary action taken against you by the agency regulating your license, in this state or any other jurisdiction? (Authority: T.C.A. § 63-51-105(a)(8)) YES ❒ NO ❒

If "YES", list name(s) and address(es) of agency(s) and a brief description of the final disciplinary action(s) and stated reason(s) for taking the action. (Attach additional sheets, clearly labeled with this question number, if necessary.)

	AGENCY NAME	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION
1.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

2.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

3.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

Practitioner's Name_____ **License #**_____
Profession _____

B. Within the previous ten (10) years, have you ever had your hospital privileges revoked or involuntarily restricted for reasons related to competence or character by the hospital's governing body? (Authority: T.C.A. § 63-15-105(a)(4)) YES ❒ NO ❒

If "YES", list name(s) and address(es) medical institution(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. (Attach additional sheets, clearly labeled with this question number, if necessary)

	HOSPITAL NAME	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION
1.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

2.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

3.				

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

C. Within the previous ten (10) years, have you ever been asked to or allowed to resign from or had any medical staff privileges restricted or not renewed by <u>any</u> hospital in lieu of or in settlement of a pending disciplinary action related to competence or character? (Authority: T.C.A. § 63-51-105(a)(4)) YES ❒ NO ❒

If "YES", list name(s) and address(es) of the hospital(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. (Attach additional sheets, clearly labeled with this question number, if necessary)

	HOSPITAL NAME	DATE	DESCRIPTION OF ACTION
1.			

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

2.			

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

3.			

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

Practitioner's Name_____ **License#**_____
Profession _____

VII. CRIMINAL OFFENSES (See Instructions)

Have you within the most recent ten (10) years, been found guilty, regardless of whether adjudication of guilt was withheld, or pled guilty or nolo contendere to a criminal misdemeanor or felony in any jurisdiction? (Authority: T.C.A. § 63-15-105(a)(1))

If "YES" briefly describe the offense(s): YES ❒ NO ❒

	DESCRIPTION OF OFFENSE	DATE	JURISDICTION
1.			
	If "YES", is this conviction under appeal? (attach copy of notice of appeal)		YES ❒ NO ❒
2.			
	If "YES", is this conviction under appeal? (attach copy of notice of appeal)		YES ❒ NO ❒
3.			
	If "YES", is this conviction under appeal? (attach copy of notice of appeal)		YES ❒ NO ❒

VIII. LIABILITY CLAIMS

Have you had a medical malpractice court judgment, arbitration award, or settlement against you since May 19, 1998? (Authority: T.C.A. §63-51-105(a)(5)) If "YES", indicate the date of claim(s) and the amount of judgment(s), award(s) or settlement(s).

	ENTRY DATE OF DISPOSITION ORDER OR SETTLEMENT	AMOUNT
1.		
2.		
3.		

IX. OPTIONAL INFORMATION

A. PUBLICATIONS: List any publications you have authored in peer-reviewed medical literature: (optional) (Authority: T.C.A. § 63-15-105(a)(11))

	TITLE	PUBLICATION	DATE
1.			
2.			
3.			
4.			

B. PROFESSIONAL OR COMMUNITY SERVICE ACTIVITIES AWARDS: List any information regarding professional or community service associates, activities and awards: (optional) (Authority: T.C.A. § 63-15-105(a)(12))

	COMMUNITY SERVICE/AWARD/HONOR	**ORGANIZATION**
1.		
2.		
3.		
4.		

I affirm these statements are true and correct and recognize that providing false information may result in disciplinary action against my license pursuant to T.C.A. § 63-51-113 and/or 63-51-118.

_____ Date:_____
(Signature of Provider)

YB/G6019027/RTK-ms.70